CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of ZA
Hearing dates:	22, 23, 24 August 2022
Date of findings:	6 October 2022
Place of findings:	Coroner's Court of New South Wales
Findings of:	Magistrate Carolyn Huntsman, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody; fentanyl overdose; search of inmates; X-ray scanners; naloxone (narcan) provision in gaols
Legislation cited	Clause 46(5) of the Crimes Administration of Sentences Regulation 2014
File number:	2020/268433
Representation:	Ms Anne Bonner, Counsel Assisting, instructed by Ms Sarah Crellin, Crown Solicitors Office Mr Peter O'Brien, solicitor for the family of ZA, O'Brien Criminal and Civil Solicitors Ms Anne-Marie Mannile, Counsel for Commissioner of Corrective Services NSW, instructed by Katie Llewelyn, Department of Communities and Justice Legal

Findings:

I make the following findings pursuant to s81 of the Coroners Act 2009 NSW:

Identity : ZA

Date : 14 September 2020

Place : Shortland Correctional Centre, Lindsay Street, Cessnock, NSW, 2325

Cause of death: The cause of death was Fentanyl toxicity, with a significant condition contributing to the death but not relating to the condition causing it being aspiration pneumonia.

Manner of death: Misadventure

Recommendations

Recommendation 1

That Corrective Services NSW ("CSNSW") review Custodial Operations Policy and Procedures ("COPP") sections 13.2, 13.3 and 13.8 for the purpose of identifying whether all or one of them should be amended.

Recommendation 2

That CSNSW investigate the provision of Naloxone (aka Narcan) to correctional officers as medication to assist in cases of opioid overdose, especially and urgently in correctional centres where Justice Health medical practitioners are not present at all times of the day and night.

Non-publication orders:

A non publication order was made pursuant to s74 and also pursuant to s65 of the Coroners Act 2009 on application of Commissioner of Corrective Services – refer to Annexure NPO below. This order included an order restricting publication of the name of ZA or his family members.

A non publication order was made, pursuant to s74 of the Act, in relation to the name of ZA's cellmate (Mr JH)

JUDGMENT

Introduction

1 These Reasons for Decision are for the inquest into the death of Mr ZA, who at the time of his death, was being held in the custody of Corrective Services,

having been remanded in custody, bail refused, after being arrested and charged with criminal offences.

2 From the investigation conducted to date, it is known that ZA died from fentanyl toxicity, due to a substance ingested when he was detained in a cell at Shortland Correctional Centre.

3 Under the Coroners Act 2009 (the Act), a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily to make formal findings pursuant to Section 81 of the Act as to the identity of the person who died; the date and place they died, and the cause and manner of the person's death.

4 The inquest investigates the facts and circumstances of a death, places them on the public record, and may examine changes which could be made to prevent similar deaths in the future.

5 When a person is charged with a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care and treatment of that person. Section 23 of the Act makes an inquest mandatory where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated.

6 The coronial investigation and inquest examines the circumstances surrounding that person's death in order to ensure that the State discharges its responsibility appropriately and adequately.

7 Pursuant to s82 of the Act a Coroner has the power to make recommendations concerning any public health or safety issue arising out of the death in question and to find ways, where possible, to stop preventable deaths. There was no evidence that ZA was not appropriately cared for or treated whilst in custody. Nor was there any evidence indicating that actions taken by Correctional

Officers, or not taken, at the time of his death, caused or contributed to his death.

The evidence

8 Before an inquest is held, a detailed coronial investigation is undertaken. Investigating police compile a brief of evidence and witness statements and documents are obtained. Because ZA's death occurred in a correctional facility, it was actively and thoroughly investigated by police. The police interviewed witnesses including correctional officers. Copies of relevant digital records such as CCTV footage and Body worn footage were also examined. The coronial investigation sought evidence as to how the fentanyl came to be present in the cell, and policy documents were obtained as to expected standards of behaviour and procedures. A focus of inquiry was the searches which had been undertaken before Mr ZA, and his cell mate, Mr JH, were detained in the correctional facility, and whether these processes were adequate, in line with policy, or could be improved.

9 Given the extensive coronial investigation which precedes the inquest, the coronial brief contains evidence which answers a number of matters required to be addressed. Therefore the inquest does not examine all of the material obtained during the investigation, but explores particular aspects. All the evidence in the brief, and at the inquest, is considered in making findings.

10 In this case the evidence revealed the cause and manner, or circumstances, of ZA's death, and so the focus of inquiry at the inquest was to examine what had occurred; and also to examine the operation of particular policies that applied in the management of inmates in correctional facilities. Relevant policies included those applying in the event of a death, and the policies and resources to detect illicit drugs when inmates are admitted to correctional centres. The inquest considered whether there could be any improvements in search processes, and also whether the response to a suspected opiate overdose in gaol was adequate in this case or could be improved.

Background

11 At the time of his death, ZA was in a relationship with his partner, Ms SM. He had three children. He was doing well, in the words of his partner, he was achieving goals, which included working as a builders labourer, and completing parenting courses. She does not believe he would have deliberately ingested fentanyl with the intention to take his own life.

12 ZA had periods of drinking alcohol which at times led to behaviour requiring police involvement, and he had spent periods in custody between 1999 and 2020, often for alcohol related conduct. However, by September 2020, he had refrained from drinking for about nine months, and was attending therapy.

13 Relevantly to the circumstances in which he later died, ZA told Ms SM that he was aware of inmates in gaol boiling or smoking fentanyl patches, but that he did not do that. He also told her that he was aware that people in gaol smuggle illicit drugs into the gaol, but never mentioned doing this himself.

14 ZA was in a positive place at the time of his death and making future plans – this was reported to the Officer in Charge of the coronial investigation by ZA's partner.

15 Ms SM gave a moving family statement to the inquest hearing. She spoke of ZA's commitment to his children, and the love he held for them as their father. It was clear that ZA was much loved.

16 Ms SM was an advocate for ZA during the inquest, ensuing that she revealed his strengths as a father, partner and person. Ms SM, through her legal representative, actively participated in the inquest, questioning processes and advocating for changes that might reduce the likelihood of such deaths occurring in future.

Events on 11-12 September 2020

17 On 11 September 2020, following an argument the day before, ZA drank alcohol during the day and then went home, which led to Ms SM calling police. ZA went out again and returned after midnight. By then he had consumed more alcohol, and his behaviour prompted Ms SM to call police again. He smashed a window and was yelling, and sending Ms SM text messages. He did not enter the premises. Police located him behind a fence in the adjoining property and arrested him. He was moderately affected by alcohol. Ms SM has told police in her statement, that ZA was arrested in a rush. Police conducted a general search of him and found a wallet but no other items.

18 Police took ZA to Gosford Police Station. He was taken to a charge room under a custody manager. He was assessed as having no injuries or risk of self-harm. While in custody at Gosford, the police officers responsible for his custody conducted regular welfare checks. He charged with contravening an Apprehended Domestic Violence Order (ADVO), damaging property and other related offences, and was refused bail.

19 As to circumstances of ZA arrest, the officer in charge of the coronial investigation (OIC) confirmed that he was not arrested for drug charges, and that he had a very limited history of drug related offending – there was one previous conviction for possessing prohibited drugs, in 2013, and the drug involved was cannabis. He was not otherwise known to police for use of drugs and was not known for use of opioids.

20 The OIC clarified that a "general search is a frisk search, pocket check, pat down to look for concealed items". When arresting police performed this search on ZA, only a wallet was found. It appears police felt no need to strip search Mr ZA.

21 ZA was first strip searched, after his arrest, in the Newcastle cells by Corrections officers, and this was "a regulation strip search" (detailed in para 102 of the OIC statement). A regulation strip search was also conducted on arrival at Kariong Intake and Transit Centre ("Kariong") (described below).

22 At about 1pm on 12 September, ZA was taken to Kariong in a police vehicle. He was handcuffed during the trip. He was transported with another inmate, Andrew Boers.

23 When they arrived at Kariong ZA was escorted to a holding cell. And was searched by Senior CO Vidler who gave in the inquest, that he did not find anything, and that ZA complied with all the directions he was given. ZA was then escorted to a cell (Unit 2). He remained in that cell overnight.

24 Senior CO Vidler recalled ZA's arrival at the centre, and that he was handcuffed when he first saw him – that is, he was handcuffed on arrival at Kariong (inmates usually are at Kariong for a day and then move on). Senior CO Vidler told the inquest that he had a discussion with the police who transported ZA to Kariong, and was told that there were no issues of concern. When ZA got out of the police vehicle Senior CO Vidler asked him the usual questions he asks first custody inmates – if ZA had any concerns or self harm concerns. Senior CO Vidler did not see signs of intoxication – no glassy eyes, no slurring, he was walking ok.

25 Senior CO Vidler described searching ZA - he said it was a Regulation strip search (being the Corrective Services NSW (CSNSW) Custodial Operations Policy and Procedures ("COPP"), Part 17.1 (Searching Inmates) – the COPP 17.1, the strip search procedure).

26 Senior CO Stephen Vidler is an experienced correctional officer, having performed the role since 1988. He was asked about his experience of conducting searches of inmates and observed that he had conducted thousands of searches.

27 Senior CO Vidler agreed that sometimes they detect contraband during a strip search – and noted that one way to secrete contraband is to ingest it, another way is to insert in the anus – especially if inserted further in. Other places contraband can be hidden include the mouth, nose and ears. Senior CO Vidler

has not ever detected secreted fentanyl. He would also search clothes worn by the inmate.

28 Senior CO Vidler stated that they don't make the inmate squat (this is the more invasive, less dignified strip search), without grounds of reasonable suspicion. Such grounds can include an inmate looking intoxicated or behavioural signs such as aggression. In making that assessment, the fact that an inmate appeared sleepy would not necessarily lead him to form a view he was intoxicated.

29 When asked about his experience of search by X-ray body scanning, he did not have that experience as it is not in use at Kariong nor where he has previously been stationed.

30 Senior CO Vidler stated that the more invasive strip search (bend over or squat or spread cheeks) would only be asked of an inmate on reasonable grounds and then a report to the gaol Governor is required.

ZA's cell mate

31 Mr JH shared ZA cell at the time when ZA died. Mr JH was arrested on 10 September 2020, when police attended his residence at about 2.30pm to execute a search warrant. In the residence various items were found that were the subject of charges later laid by police. Mr JH, after committal/charge certification proceedings, was sentenced in the District Court, on agreed facts, in relation to a number of charges to which he pleaded guilty (some were placed on a Form 1).

32 The agreed facts on sentence ("agreed facts") indicate that chemistry equipment was found in the laundry, storeroom, and lounge room of the premises; and Mr JH's fingerprints were located on some of the equipment. Other chemistry equipment was found in the garage to the premises. When searched on 10 September he was found to have a small quantity of cannabis on his person, this was subject to a charge which, being a summary offence,

was referred to the District Court with all his other matters pursuant to s166 of the Criminal Procedure Act.

33 The agreed facts also indicate that a green plastic folder was sitting on top of a table in the kitchen. Inside it, police located two printed documents. The first was a 5-page document relating to the chemical composition of fentanyl and dosage recommendations. The second was a 5-page document titled, "Method for the preparation of fentanyl." This item was the basis of one of the charges.

34 In addition, the agreed facts reveal that a jar of MSM powder (common cutting agent) was found on the kitchen bench; a clear resealable plastic bag containing black seeds (suspected to be poppy seeds) was found in the front lounge room; the granny flat (where Mr JH lived) was searched. Police located in the granny flat the following items - syringes; plastic bags containing small amounts of green vegetable matter; a cardboard box contained a glass flask wrapped in bubble-wrap; and several resealable plastic bags containing unknown white powders.

35 The agreed facts also record that in the granny flat, a safe containing a paper package in a plastic resealable bag, was located. The paper package contained a powder, which was subsequently analysed and found to contain fentanyl. The gross weight (including packaging) was 4.1 grams.

36 During his arrest Mr JH’s hands were placed in plastic bags so they could be forensically tested.

37 During an interview with police Mr JH did not make any admissions to manufacturing fentanyl. After the interview, Mr JH was taken to the charge room, and placed back in the dock. At that time he was wearing a large black jacket, a t-shirt, shorts and thongs. The Officer in Charge of the coronial investigation noted that on arrest Mr JH was wearing the shorts and t-shirt and thongs, the police brought the jacket from the house (where he had been arrested) to the police station, and he is later seen at the police station with the black jacket draped over his shoulders (his hands being in bags to allow

forensic testing). After the interview and forensic testing he is again seen in the dock wearing the jacket.

38 The agreed facts recorded certain conversations between Mr JH and Police at the time:

> Police had a conversation with the offender that was recorded on BWV. One of the officers asked, "What's in them?" The offender replied, "What do you mean?" The officer said, "In those glassware things." The offender said, "Unsuccessful things off the net and stuff. That's it. There's not anything that works." The offender declined to say on camera what he was trying to make.
>
> Police sought further information from the offender about the nature of the chemicals found in the house. The offender was cautioned. He said to police, "There is caustic soda, hydrochloric acid, acetone, dichloromethane or methylene chloride which is basically paint stripper and um ... that's about it."

39 In the agreed facts in Mr JH's sentence proceedings, he said that he was just tipping soapy water down the sink when police arrived and saw him. Mr JH's hands were later swabbed, and the presence of fentanyl was indicated.

40 The agreed facts on sentence contained a Statement of responsibility by Mr JH as follows:

> The offender knowingly took part in the manufacture of the fentanyl that was located in the glass baking dish in the laundry (2 grams), as referred to in paragraph 21 above.
>
> The commercial quantity of fentanyl, as prescribed in Schedule 1 of the Drug Misuse and Trafficking Act 1985, is 1.25 grams. While the offender took part in the manufacture an amount which exceeded this, it is accepted by the Crown that he did not know that the amount manufactured by him exceeded the relevant quantity.

41 Mr JH ultimately pleaded guilty to manufacturing an indictable quantity of fentanyl, contrary to s 24(1) of the Drug Misuse and Trafficking Act, with two offences on a Form 1, including possessing instructions for manufacturing fentanyl.

42 It was also agreed that located in the laundry was a glass baking dish containing 2 grams of a clear, crystalline substance containing fentanyl (this was count 1

on the indictment). Other glass bowls contained a white residue. Mr JH's fingerprints were on drug manufacturing apparatus located in the laundry and in a storeroom located next to the laundry.

43 As was conceded by Mr JH's representative during the District Court sentence proceedings, fentanyl is an extremely dangerous synthetic opioid, as reflected in the penalty but also in the prescribed amounts for an indictable quantity - 250 grams for amphetamine, 1.25 grams for Fentanyl; so 2 grams containing fentanyl was significant. Fentanyl was also found in a powder packaged in paper, in a resealable plastic bag in a safe in his bedroom, which he reportedly had purchased elsewhere.

44 On 14 September 2021, Mr JH was sentenced in the District Court to an aggregate sentence of 2 years, 6 months imprisonment, expiring on 13 March 2024, to be served by way of intensive corrections order. He gave evidence on sentence that he was making it because he was addicted to opioids and was making sure that if he couldn't pick up his methadone, he would be all right. He intended that it would be diluted and injected. At the inquest he explained that he was worried supply would be affected by covid lockdowns.

45 Returning to Mr JH's arrest, he was conveyed by police to Waratah Police Station, arriving at about 5pm. He was seated in a dock in the charge room, and was then interviewed. Mr JH was refused bail, and then at about 11pm was transferred to the Newcastle Court cells and taken into Corrective Services custody.

46 In Newcastle Court cells, Mr JH was strip searched in an observation cell, by Correctional Officer Adam Jones. No contraband was located in the search, and Mr JH was observed to be calm and compliant. He was escorted to a cell with two other inmates, where he was held overnight. That cell was monitored with observation cameras which were checked from time to time.

Mr JH and ZA at Kariong

47 On the afternoon of 11 September 2020, Mr JH was transferred to the Kariong centre and was on his own in a cell overnight, and on the second night shared with another inmate.

48 While ZA was transferred to Kariong on 12 September 2020, he did not share a cell with Mr JH at Kariong.

Search of Mr JH at Kariong

49 As noted above, Mr JH was subject to a regulation strip search in the Newcastle cells. He was again subjected to this type of search on arrival at Kariong. On both occasions nothing was found.

Searches at Shortland Correctional Centre

50 At about 9am on 13 September, ZA, Mr JH and Mr Boers were transferred to Shortland Correctional Centre, arriving at about 1.20pm. While still at Kariong ZA was interviewed and raised no immediate medical or wellbeing concerns and he appeared to be casual and comfortable when he arrived at Shortland. The three inmates were placed into holding cells and their handcuffs removed. Each inmate was strip searched by Correctional Officer (CO) Jeffrey, who did not locate anything unusual. Each was then removed, interviewed and medically screened.

51 Mr Boers was an inmate whose statement was recently obtained by the OIC. Mr Boers was arrested on 12 September 2020 in Springfield, Central Coast, for possession of prohibited drugs (methylamphetamine and cannabis) and also for supply of methylamphetamine. In his statement Mr Boers denies any knowledge of fentanyl or opioids and police records show no connection of Mr Boers to opioid use, possession or supply.

52 CO Jeffries was at the time casually employed but is now permanent at Shortland – he gave evidence at the inquest that previously he has had many different job occupations. CO Jeffries stated that he undertook strip searches

from the very start of his work as CO, and as at September 2020 he would have undertaken hundreds of searches (of new arrivals to the centre, and for visits etc). He recalls meeting ZA and Mr JH on their arrival at Shortland.

53 CO Jeffries told the inquest that on arrival they were held in an external holding cell (a yard cell). He searched ZA first as he volunteered himself for first search. JH was not reluctant but not eager, but that is not an unusual presentation.

54 CO Jeffries stated that ZA was calm and compliant – ZA seemed in good spirits, was chatting and friendly. Mr JH was also friendly and compliant. CO Jeffries thought Mr JH seemed somewhat lethargic, and he recalled he was lying on the bench in the holding yard. Mr JH did not present so as to indicate reasonable grounds to do the extra invasive search, and the lethargic appearance did not cause CO Jeffries to think Mr JH was drug affected. As to Mr JH looking tired CO Jeffries stated that there are a number of inmates who arrive to the centre and appear tired – this is because they have often been in cells for some hours after arrest and before arrival, so they arrive tired.

55 While CO Jeffries noted that he was not trained to medically assess someone he does actively look for signs of contraband and behaviours consistent with hiding something. Nether ZA nor Mr JH made any such indications during the search.

56 CO Jeffries has observed the X-ray body scanners in use at Shortland but he has not yet been trained in their use. The scanners are used on inmates who are new custodies, and during visits, and where there is suspicion.

57 The search of ZA and Mr JH did not involve the more invasive strip search which involves bending over, squatting etc because there were “no indicators leading to that requirement”.

58 Later, at 4.47pm ZA and Mr JH were escorted to Cell 233 in Block F, provided with a meal and the cell was locked.

The knock up call

59 At 3.31am the next morning, which was 14 September 2020, Mr JH used the intercom system inside Cell 233 to contact correctional officers, saying that he needed Narcan, and that ZA was dying and not breathing. He said that ZA had had some "smack". He also said that ZA had thrown up all over himself, had a light pulse and was cold. Mr JH said he had placed ZA into the recovery position and he was not responding.

60 Senior CO Osman Zerdo was contacted by radio, and he, with a number of other officers, went to Cell 233, arriving at 3.37am. Senior CO Zerdo was the Officer in Charge that night, and gave evidence in the inquest. The officers opened the cell door flap before they went in, and saw ZA motionless on the right side bed in the recovery position and Mr JH standing.

Cause of death

61 Dr Leah Clifton, Forensic Pathologist, conducted the autopsy examinations after ZA's death, which included a toxicology examination. Fentanyl was detected at 0.02mg/L in a sample of preserved blood. No alcohol was detected. Paracetamol at less than 5mg/L was detected.

62 Dr Leah Clifton, Forensic Pathologist, after careful examination, excluded other causes of death such as by injury, or disease. Dr Clifton found that the level at which fentanyl was detected, post mortem, was considered to be potentially lethal, especially in the context of ZA not being known to be prescribed fentanyl or to use it regularly. She stated that fentanyl is an extremely potent synthetic opioid (that is, with a potency 50 to 100 times the potency of morphine) with a rapid onset and short duration of action. Fentanyl is known to cause respiratory centre depression, coma and seizures in high doses.

63 Dr Clifton concluded that the direct cause of ZA's death was fentanyl toxicity. Dr Clifton also identified aspiration pneumonia as a significant condition contributing to the death but not relating to the condition causing it. She

explained that this likely represented a prolonged period of unconsciousness, due to drug intoxication, in the period before death.

64 A full internal examination was conducted by the pathologist and no internal disease process contributing to the death was revealed. Nor was there any large bleed discovered – it is relevant to note this, because one of the ambulance officers at the scene noted there may have been a bleed, or ZA may have otherwise been unwell. However, as previously noted, Dr Clifton did observe aspiration pneumonia.

Events in cell 233

65 When the correctional officers went into the cell, Mr JH was taken out and placed in Cell 234. ZA was not responding, and the officers could not find a pulse. The officers commenced CPR, and Senior CO Zerdo asked for the Manager of Security and Governor, and ambulance and police, to be called. By then, ZA body was cold to touch and a dark fluid was coming from his mouth and nose. A handheld camera was retrieved and footage was taken, and one of the officers, CO Emma Pywell, took a time log of events.

66 At 3.45am a defibrillator was brought in and used but it was not successful in reviving ZA. At 3.47am the officers moved ZA to the floor and continued CPR. There is a record of a light pulse having been detected at 4am. Ambulance officers arrived at 4.07am. They assessed ZA and at 4.12am, pronounced that he was deceased.

67 Police officers arrived soon after, at 4.24am. The Officer in Charge of the investigation, Sergeant Rob Ayscough, was the on-call detective for the Hunter Valley Police District, and he arrived at 5.50am.

Mr JH in cell 234 and dry cell

68 In the meantime, Mr JH had been placed in Cell 234. CO Limn and Senior CO Zerdo checked his welfare at about 4.18am. Mr JH told them that he and ZA had both had some “smack”, that they snorted it through the nose, and that the

amount was about the size of a fingernail. He said that ZA had used the majority, that ZA owned the substance, and that it was “white, maybe heroin”.

69 Police entered Cell 234 at 4.28am and the water to that cell was switched off at 4.36am. Detective Ayscough recorded an interview with Mr JH commencing 5.52am. A copy of that interview is included in the coronial brief of evidence, but in short, Mr JH said that at 12am or 1am, Mr JH woke to ZA pacing the cell, holding a small plastic bag containing white powder which ZA said was “gear” or “smack”, about a fingernail full (maybe about a point or a couple of points). ZA offered Mr JH some, and they both snorted some of the white powder, about half of it. Then, Mr JH said, ZA flushed the plastic bag down the toilet. Mr JH fell asleep, but woke a while later to ZA gurgling or gargling. Mr JH rolled him over and then buzzed up to notify the correctional officers. Mr JH denied harming ZA.

70 After the interview concluded, at 6.55am, Mr JH was moved to a “dry cell”, which is a cell with no running water, flushing toilet or drain. He was strip searched, and he underwent a urine test. Methadone and fentanyl were later detected in the analysis of that sample. Not long after 11am, Mr JH passed faeces into a bucket, but did not pass any foreign objects or materials.

71 Detective Ayscough spoke with Mr JH again at about 11.20am. That time, Mr JH said in effect that he did not want to get ZA into trouble when he came to, so before he called the correctional officers, he took the rest of the gear out of ZA’s pocket and put it in his own anus so the officers wouldn’t find it. Detective Ayscough then conducted a further recorded interview of Mr JH and Mr JH effectively repeated what he had said. He denied that the drugs were his or that he brought them into the correctional centre.

72 Mr JH also gave a witness statement on 15 September 2020 which was generally consistent with his second account to Detective Ayscough, with additional detail. He said the drug was a white powder, which ZA had in a “satchel”, and which Mr JH said looked and tasted like heroin. He said the strip search after the first interview did not locate the satchel because he had pushed

it right inside his rectum to his second or third knuckle. The statement also stated that in the dry cell, after he had passed faeces, he knew that he had passed the satchel because he could not feel it anymore.

73 As detailed below, Mr JH evidence at the inquest hearing departed from the evidence he gave previously in his statements and interviews.

Evidence of correctional officers who attended the medical emergency in cell 233

74 CO Pywell told the inquest that from her memory 8 officers attended the cell after the knock up call, and included herself, Verdo, Lim, Sandu, Pannicker. She agreed she was directed by the officer in charge on the night, Senior CO Verdo, to move Mr JH into cell 234, this was done pretty much as soon as she arrived – the direction was to remove all non involved parties. She recalled that she moved him to cell 234 – she did not now recall physically walking with him, or his demeanour, but does recall opening the door to the cell for him and placing him in.

75 CO Pywell was not able to recall the time that the water to cell 234 was turned off, but agrees the cell had a drain, a sink and a toilet. She did not have any role in turning off the water, or in later moving Mr JH to a dry cell. She was referred to her incident report where it is recorded that she waited outside cell 234, monitoring the cell until detectives arrived.

76 It was her role to prepare a time log (tab 57) – she started the log at about 3.39am. She could not now recall how she saw times, (eg watch or other device) the times on the log may have been estimations. She agreed that the log records CPR being undertaken, and records CO Pannciker going to get the ambulance. She agreed that at one point she handed the log over to Officer Jennifer Lim, because at that time she was assisting with the CPR attempts.

77 She gave evidence that she recalled receiving an initial 10 week period of training on commencing as a CO, but does not recall the particular policies (COPPS policies) – during this incident she was taking direction from the senior

officers on the night. She does recall receiving first aid training, but does not recall receiving specific training for overdose. She however agreed, when asked during her evidence at the inquest, that it might be beneficial to receive such training.

78 She agreed that she was dealing with a medical emergency this night, but doesn't recall the specific training that she received on the applicable policies, or COPS, that apply in this situation. There are first aid boxes located in various areas, however she doesn't know of the medicines contained within these.

79 CO Pannicker gave more detailed evidence at the inquest and his evidence indicated some familiarity with applicable policies/COPS.

80 CO Pannicker confirmed he was involved in moving Mr JH to cell 234, and confirmed his impression of Mr JH was that he was physically shaken, he presented a someone who had seen a tragic event, for this reason CO Pannicker asked him if he was ok and he said he was. CO Pannicker could not recall further conversation with Mr JH. He cannot recall being asked to move Mr JH, but said it is standard procedure to remove those uninvolved in the medical emergency, to allow officers to concentrate on the emergency needs. Mr JH was alert and appeared well and did not need medical attention, whereas ZA was in need of attention. After removing Mr JH, CO Pannicker went to get a hand held camera. He also utilised the defibrillator. The first aid training he received included CPR and defibrillator. CO Pannicker told the inquest that at one point he shouted out that he felt a pulse – he felt it once only. He saw the defibrillator light up just that once when he felt the one pulse. It was a weak, single pulse that he felt.

81 Later CO Pannicker did a welfare check, on one occasion, on Mr JH by looking through the flap – Mr JH was at that time seated with his head in hands and CO Pannicker asked if he was ok and he said, yes, he was ok.

82 CO Pannicker recalled that the police officer interviewed Mr JH in the cell and requested the water be turned off in the cell – and so CO Pannicker then did

so. This occurred just after the police came, at around 4.30am. It is quick to turn the water off, it is just a power switch.

83 It was put to him that a document in evidence recorded that: “CO Panniker comments ‘there is a satchel at the end of his bed”. CO Pannicker responded that “I saw it on the video, it wasn’t me that said those words, …voice was more of Australian accent”. He also was not in the cell at that time (he left to go to gate to meet police).

84 Mr Pannicker was asked about his 10 weeks of training, and he recalls being shown the COPS during training. He does refer to them and does look at them from time to time, on his own initiative (they are available to him at work). He has reviewed medical emergency COPS over time and also since ZA’s death. In relation to COPP 16.1 serious incident reporting – he recalls looking at this after ZA died. He was referred to tab 63 “13.2 Medical Emergencies”. He agreed he looked at this to update himself. In relation to “13.3 Deaths in Custody” (tab 64) – he has recently looked at it, but he cannot recall if he looked at it around the time of ZA’s death. In relation to the policy behind tab 64B “Crime Scene Preservation” he believed he looked at this after ZA’s death.

85 CO Pannicker was asked to describe how the policies work together – he stated that in delivering first aid we need to be careful not to disturb the scene – we tried to ensure this, although we had to move ZA from the bed to do CPR. He tried to preserve scene as much as possible while responding to medical emergency, and that includes not removing any items from the cell. However, he stated he was not there the whole time so can’t speak for the whole period.

86 CO Pannicker has been a CO since 2014. He said he has had no previous experience of an overdose incident, but has had prior involvement in medical emergencies – most of these were in the day time where a nurse was present, he could not recall any overnight issues. During the day Justice Health are present and deal with medical emergencies, they are not present overnight. Justice Health are based within Shortland Centre but not overnight. They cease duty at around 9pm and return in the morning.

87 He was taken to the COPS/Policy behind tab 64B “Crime Scene Preservation” – this was his first serious incident, however his general approach is to not disturb the scene and to secure the cell. CO Pannicker didn’t think about whether Mr JH had forensic material on him – his focus was the medical emergency and concerns too about Covid.

88 Seven or eight officers responded to the knock up call – from Mr Pannicker’s memory 6 were engaged in administering CPR, and one doing time log and one doing hand held camera; also officers needed to attend the gate to let in the ambulance, police etc when they arrived.

89 He said the officers took turns in doing CPR, it was exhausting doing the chest compressions, so they took over from each other. He said they would also have been tired as they were doing twelve hour shifts and this was towards the end of the shift; towards the end of a long day.

90 CO Pannicker stated there is access to first aid kits and these do not provide medications, just bandages and such items. When asked whether he knew he was dealing with a drug overdose he stated that he believes the senior officer told him of the report of overdose.

91 He was taken by Mr O’Brien (legal representative for the family) to the time log record, and Mr Pannicker agreed that he was in the first group of responders to the cell. He agreed it would have been beneficial to have a medically trained person on staff overnight at Shortland.

92 Senior Correction Officer (Senior CO) Zerdo was officer in charge on the night. He has been a CO since 2004, a Senior CO since about 2015, and he commenced at Shortland in June 2020, so as at September he had been there 3 months. On a night shift if there is only one senior, then the senior is the officer in charge with governor delegations – on this night Senior CO Zerdo was the officer in charge.

93 He coordinated the emergency response to cell 233, and he agreed that about 6 or 7 officers attended. Mr JH's Knock up call was received by the monitor, CO Morris, he then contacted Senior CO Zerdo on radio. He recalled words to the effect of – situation, cell no 233, medical attention required. He noted that the incident report refers to overdose; he cannot now recall what was in his mind, but believes he was focused on medical response. This was his first direct experience of a drug overdose in custody. He had been involved before in medical emergencies but not a drug overdose emergency that he can recall.

94 He had some experience of inmates using illicit drugs in custody but no experience of fentanyl to his knowledge. He has previously come across heroin use by inmates.

95 Senior CO Zerdo recalls a conversation that he had with Mr JH on that morning, it could have been before the ambulance arrived – It was a wellbeing check but he did ask him questions as to whether drugs were involved, and Mr JH provided responses which he recorded. He agreed his incident report, at the time, was made trying to record what happened as best he could. As to conversations with Mr JH at the time, he cannot today recall that anything further was said, to what is recorded in his incident report.

96 Senior CO Zerdo agrees that he would, with hindsight, have had someone monitor Mr JH for his welfare. He believed every officer in cell 233 was helping by doing CPR. Other things required included calls made to monitor, and contact with ambulance, police and security. Senior CO Zerdo recalls that approximately 10 officers were on duty that night at Shortland – one in the gate house, one in monitor role – Senior CO Zerdo believes that every other available officer was involved in helping in cell 233.

97 He stated that lack of resourcing can be a concern, but in his view, of more concern is lack of Justice Health staff presence overnight. He has first aid training but no medical training. Justice Health staff are present 7am to 9pm. He can seek advice from the after hours nurse (can be contacted after 9pm, for

phone advice only) but if anything more is needed then he must contact an ambulance.

98 Senior CO Zerdo stated that after contacting the monitor room to direct the ambulance be contacted, it seemed an inordinately long time before they arrived. “It felt very long”.

99 Senior CO Zerdo agrees there was opportunity for Mr JH to dispose of any contraband, if he possessed some, in cell 234 before the water was turned off, down the drain or toilet.

100 He is aware of COP 13.8 and does refer to it, but cannot recall how often he looks at it. Over time he does refer to it as required, and also received some training as part of becoming a Senior CO.

101 He recalls that this COPP was in place from around 2018, the standard operating procedure predated it, and was replaced by the COPP.

102 As ZA was experiencing a medical emergency, that was his focus. He agreed he should also preserve the scene. However issues of safety and medical emergency take precedence to scene preservation and this was his approach. Senior CO Zerdo agreed that if a nurse was present, he could have focussed on other relevant issues as officer in charge (eg crime scene preservation). He also agreed that in the absence of a nurse, some training in dealing with overdoses would assist. But his overall personal view was that the presence of an after hours nurse would be the most beneficial.

103 When asked whether he was focussed on forensic examination of Mr JH he said that he is to remove the second inmate from the scene, and provide help and attention to the unwell inmate. Once he had secured Mr JH his focus was on providing medical attention and trying to maintain ZA’s life.

104 Senior CO Zerdo told the inquest that the Duty of First responders (DOFRO) – includes removing uninvolved persons and attending to the inmate who is

requiring help. Their emphasis as DOFROs was to give first aid and life support to ZA.

105 Senior CO Zerdo agreed that the presence of illegal drugs in gaols provides a risk of harm to inmates and staff.

106 Senior CO Zerdo is not trained in the X-ray scanner machines, however, when asked of their efficacy to better identify drugs in cavities, he stated there is a caveat as the efficacy rests on the skill of the person interpreting the scan image to identify the item. However he believes that an X-ray scanner is a good additional measure for reducing drugs in the gaol.

The report of the satchel

107 A video recording made in the cell records a voice saying there is a satchel on the bed (a small resealable plastic bag commonly used to contain drugs). CO Pywell and CO Pannicker did not recall hearing those words, and CO Pannicker emphasised that he saw nothing removed from the cell, and that it is standard practice to retain the scene intact as best as is possible.

108 Senior CO Zerdo did not recall hearing any reference to a satchel on ZA's bed. He was not aware of satchel on the bed and not aware of anyone removing same. He stated that upon ambulance officers making the declaration that ZA was deceased they left the cell: he made sure the video was still recording and that the cell was secured, no-one was to enter.

109 Senior CO Zerdo was referred to paragraph 17 of his statement "secure cell 233 and restrict access" – he told the inquest that he doesn't recall now his exact actions to achieve this. He noted that the cell's open doorway is in view for some time during resuscitation, as well as afterwards, on the video camera footage, and he was not, and is not aware, of any items being removed.

110 Ultimately, no officer who gave evidence could say what that satchel supposedly was. Importantly, there is no evidence from which to infer that a correctional officer removed a satchel from cell 233. When police crime scene

examiners searched the room, no satchel was identified. It is not known what it was that was reportedly seen. I find that the evidence indicates that there was a report by an officer of having seen a satchel, but what that was is not known, and whether, if it existed, it had any connection with ZA's death is speculative.

Mr JH's evidence

111 Mr JH's evidence was initially provided by way of a record of interview with the officer in charge, which was conducted on body worn video at the Shortland Correctional Centre in the hours after ZA's death, and was also a statement provided by Mr JH on 15 September 2020. In his written statement he describes his history of drug use, primarily heroin, on and off for the past 20 years and his arrest on 10 September 2020 for the criminal charges involving manufacture of fentanyl. In his written statement he describes meeting ZA when they both arrived at Shortland Correctional Centre and when they were placed two out in a cell in F-wing. He stated they were locked in the cell for the evening, and they ate their meals and then watched television and he recalled the three Amigos movie was on.

112 In a statement he described witnessing ZA snorting some powder later on in the evening and asked to have some. He also stated that they discussed later that they were not feeling the effects of the powder. He then described waking at 3 am hearing ZA gasping for air and he was immediately concerned. He describes in his statement trying to obtain a response from ZA and hearing him gargle. In his statement he says he rolled ZA over and saw black coloured liquid come out of his mouth so buzzed up using the knock up call system. He describes secreting the satchel of white powder which he stated was in ZA's pocket, between his backside cheeks. He said he did this so ZA would not get into trouble.

113 Mr JH described during the knock up saying that there was a need for Narcan because the guy had dropped and was not breathing. He checked ZA's pulse at that time and said he reported there was a weak pulse. He gave him mouth-to-mouth, and also CPR, and corrections officers arrived after a couple of

minutes, although it seemed like an eternity to Mr JH. He was placed in an adjoining cell but could still hear correctional officers working on ZA for about 30 minutes, and also making references to an ambulance by radio. He heard a request for the ambulance to come and check on him, (Mr JH). He stated the ambulance did check on him and then left him locked in the adjoining cell. Police arrived and spoke with him and the water was then turned off in the adjoining cell.

114 Mr JH states that the correctional officers were too busy to search him when he was placed in the adjoining cell, they were too busy working to save ZA's life. Later he was stripped and intensively searched, however he states that he had pushed the satchel far up into his rectum so it was not located during the search. Mr JH states that after the search he was taken to a dry cell on his own. At a later point in time he passed faeces into a bucket in the dry cell and he believes that the satchel came out at that time because he could not feel it inside any more. When he gave evidence at the inquest he was specifically asked whether he used the toilet in cell 234, prior to being placed in the dry cell, and he could not recall whether he had done so or not. He did however state his recollection that he passed faeces into a bucket in the dry cell and believed that was when he passed the satchel containing the fentanyl.

115 At the inquest Mr JH attended and gave oral evidence. At a point in his evidence, he objected on the basis that his answer might tend to incriminate him. He had the benefit of legal advice and representation from a solicitor with the Legal Aid Commission of New South Wales. I determined that the objection was reasonable and he gave evidence willingly and was granted a certificate under section 61 of the Coroners Act. The transcript will record my reasons for decision for granting the certificate, I will not repeat them in these written Reasons for Decision.

116 Mr JH told the inquest that the evidence provided in his written statement, and also the interviews on the body worn video, was partly true and partly not true. He gave evidence that he possessed the powder, being fentanyl, not ZA.

117 Mr JH said that he did not meet ZA at Kariong, he met ZA when they came off the bus at Shortland Correctional Centre.

118 He noted that the statement in writing which he provided to investigators, and the interviews were shortly after ZA died, and that was over 2 years ago. He was aware that the brief of evidence for the inquest, has the agreed facts on sentence and the transcript of his evidence at the District Court. In response to questions from Counsel Assisting Mr JH stated that at the time he was trying to manufacture fentanyl at home as he was worried the supply of both methadone and opiates given the Covid lockdown at the time, and he confirmed he had indicated that during sentencing before the District Court.

119 Mr JH agreed that he had pleaded guilty to certain charges and received a sentence of imprisonment to be served by way of an Intensive Corrections Order (this is a sentence of imprisonment served in the community under the supervision of the Office of Community Corrections – such orders contain standard conditions and additional conditions). The additional conditions on Mr JH's order included abstinence from illicit drugs, community service work, attendance at a psychologist, amongst other conditions. Mr JH told the court that as well as complying with the conditions imposed by the Intensive Corrections Order he had attended a program known as at the Equips program.

120 Mr JH told the court that what occurred when he was in the cell with ZA had changed everything for him. He stated he no longer associated with former drug using acquaintances, and had maintained abstinence. This was a major change for him. He stated that whilst he has seen overdoses before, the person had always been revived, and he had never been through what occurred with ZA. He stated that he did not want to make himself the centre of things in saying this, he observed that the focus of the inquest was ZA who had tragically lost his life.

121 It was clear that Mr JH had made a decision to tell the Coroner's Court and the family what had occurred. He agreed that he gave a false version in his

statement to police when he claimed that ZA had brought the substance into the gaol and was in possession of the substance.

122 Mr JH said that what occurred was as follows. He said that he, Mr JH, went over to a corner of the cell where he was snorting, secretly, a bit of his fentanyl which he had on his person, having brought it into the gaol. He said ZA asked him what it was. Mr JH said he explained to ZA that it was fentanyl, that he had not had time to test it, and that they had a conversation for about 20 minutes, where he explained how he got the fentanyl in and what it was. Mr JH maintained that they each sniffed it nasally, and then they sat up watching some television for about 30 minutes. He said he told ZA that it was a serious drug, an opiate, and not a recreational drug being ordinarily a prescription drug.

123 When questioned during the inquest to give the exact conversation that he had with ZA, he said he couldn't recall exactly, and added "I've dreamt about it too many times, don't know if I can remember the words correctly". Mr JH maintained that ZA wanted to try a little to see if it would work, and Mr JH also wanted to have some. Before they both went to sleep they were talking, laughing together and watching television and that they both agreed that they hadn't felt any effect from the drug they had taken.

124 Mr JH said that both he and ZA then fell asleep. Mr JH gave a similar version to that in his written statement about waking up in the early hours of the morning because he heard ZA having difficulty breathing, he said he heard a laboured breathing. He was worried, he remembered hearing a rattling breath, and when he went over close to ZA's bed, he could hear gurgling in the back of ZA's throat. He said he turned him over and liquid came out. He stated that he is aware that when people have too much of an opiate they might vomit and he was concerned about that, so this was why he turned ZA over. He made the knock up call and also gave some mouth-to-mouth resuscitation. He described trying to put the breath into ZA, to breathe into him, but the breathing was still difficult and he could feel a weak pulse. He believed that if he could keep him breathing, and if the correctional officers could keep doing CPR, and then the

ambulance would arrive, that ZA would be revived and they would help him survive. It did not enter Mr JH's mind that ZA would not be able to be revived.

125 Mr JH, in response to questions asked, said he had seen on at least two prior occasions a person who had taken fentanyl and was potentially suffering an overdose, revived with Narcan and he had also seen this at least four or five times before for heroin users. He knows that if Narcan is administered people can be revived and he thought Mr JH would survive. That was why when he made the knock up call he said that Narcan was needed and it was an emergency. He agreed he remembered saying "mate, we've gotta drop here, we need Narcan, emergency, emergency get off your arses".

126 It was put to him by the legal representative for ZA's family that he had said that ZA had taken smack, and he was asked why he described it as smack and he gave two reasons. Firstly, he had not yet been charged with any offence in relation to fentanyl, and secondly fentanyl is an opiate just like heroin, but heroin or smack is a better-known opiate, so he described it as smack with the awareness that the treatment would be the same, both respond to Narcan.

127 Mr JH was questioned about his experience of being searched. He said that he had never been through an X-ray scanner. He agreed that on this occasion the search did not find the item, the fentanyl, which he had secreted in his rectum. Mr JH said the searches at the gaol are quite thorough - he said it could not be made any more intrusive without the officers sticking a finger up and conducting a medical type examination. He said "they make you squat and cough and if it's big enough it will generally pop out, but this was small". Mr JH's view was that on this occasion it was such a small item, and inserted far up, so it was not detected on strip-searched nor was it detected on the more invasive strip-search which was conducted after he was removed from cell 233 and placed in cell 234. On that occasion he was asked to squat and cough.

128 In relation to how he got the substance into the gaol Mr JH said that when the search warrant was executed at his home on 10 September he had been making fentanyl, but he was not sure that the process was really working. He

said when he heard the police at the beginning of the search warrant saying "police, police, search warrant" he quickly put a small amount of powder in a small plastic bag, being a very small snaplock bag, and placed it between his bum cheeks. He said there had been dry white stuff down the side of a glass container which had been evaporating slowly and he took some of that crust or white powder off the side of the container and put it in the plastic bag and put it between his butt cheeks. He then washed the glass container and this was what he was washing when police discovered him washing an item in the laundry.

129 He was asked whether he was dressed in shorts and T-shirt at this time and he said it was his pyjamas. He agreed that when police first saw him he was tipping the liquid from the flask he was washing down the sink. He was asked about asking police for a jacket and he agreed he did so, as it was freezing outside. He is pretty sure there was no drugs in the jacket, what he took into the gaol was the drugs which he had placed in the plastic bag. The plastic bag was around the size of 4 cm x 3 or 4 cm ,and was a Ziploc plastic bag. It only had a very small amount of powder in it, perhaps one point.

130 He was asked by the representative for the family why he took the opportunity, when police were executing the search warrant, to place a small amount of the drug and hide it on his person. Mr JH said he had been arrested before, and he said police can leave you, when they know you are opiate dependent, without opiate replacement therapy (such as methadone) and he believed they used it as a tactic, to let you hang out before they interview you. He said he had been through that before, that two days of hanging out, and he did not wish to go through that again. For that reason he took a small amount with him.

Findings on the evidence of Mr JH

131 Whilst Mr JH gave evidence pursuant to a certificate, and whilst parts of his evidence were in conflict with his earlier statements to police, it is my view that Mr JH's version that he possessed the fentanyl and had brought it into the gaol should be accepted. There are several reasons for this finding. The first is that it is more consistent with all other extrinsic evidence for the fentanyl to have

been possessed by Mr JH – he had a lengthy history of drug-related offending, by contrast, ZA had only one drug-related offence in 2013 and that related to cannabis. ZA had no history of opiate use recorded against him by criminal conviction or in the police database. ZA's issues were alcohol related. Secondly, Mr JH had an association with fentanyl - this is revealed by what was found in his premises on execution of search warrant and his pleas of guilty in the District Court, as referred to above in these Reasons for Decision. Thirdly, the admissions by Mr JH, whilst made under a certificate, were otherwise made in circumstances where there was little to be gained by Mr JH and were arguably against his interests.

132 Mr JH did appear to be motivated to tell the inquest what happened to ZA, and to let ZA's family know this. For all these reasons I am of the view that Mr JH's admissions in relation to possession of fentanyl, and supply of fentanyl to ZA in the cell, and also bringing the substance into the gaol, should be accepted as evidence of what occurred.

133 The contrary view would be that by giving different versions Mr JH presents as unreliable. Whilst there may be some unreliability attaching to parts of Mr JH's evidence, for the reasons already detailed, the central matters of possessing the fentanyl, of supplying the fentanyl to ZA in cell 233, and of bringing the fentanyl into the gaol by secreting it in his body cavity, should be accepted and are reliable.

134 Mr JH's evidence included reference to his own shock and ongoing disturbance at ZA's death, and also that he has successfully maintained abstinence from offending and drug use while he has been the subject of an intensive corrections order. This context is generally consistent with his admissions at the inquest being true.

Applicable Policies

135 The coronial brief of evidence includes a number of policies which are applicable to the operations of Corrective Services New South Wales. The policies most relevant to the issues to be considered in this inquest, concern

search procedures and policies, and the management and monitoring of cellmates during and after an incident involving a potential drug overdose.

136 As to the first issue, that is, searches upon entry into a custodial centre, the CSNSW Custodial Operations Policy and Procedures (or "COPP"), Part 17.1 (Searching Inmates) applies. That policy governs the conduct of strip searching, and also contains a section on the use of low-dose X-ray body scanners as an alternative to being strip searched. Body-scanners were not used when ZA and Mr JH were received at Kariong or Shortland. One of the issues under consideration is the availability and efficacy of a body scanner as an alternative to strip-searching on reception of inmates in those centres.

137 Mr Michael Williams, the Manager of Security, State-Wide Operations for Corrective Services NSW, has provided a statement concerning body scanning and annexes Part 17.5 of the COPP, which describes body-scanning operational requirements, processes and contraband detection amongst other things. Mr Williams explains that body scanners are used by Corrective Services NSW as a security screening tool to detect contraband that may be concealed externally or internally by a person. Since ZA's death, three body scanners have been installed at Shortland Correctional Centre, at the end of November 2020. There is a commitment currently to have X-ray scanners at maximum security facilities given these are higher risk facilities.

138 An identified issue was management and monitoring of cellmates in an incident involving a potential drug overdose.

139 COPP 13.8 concerns crime scene preservation, and Part 4 of 13.8 concerns forensic evidence and procedures to be followed, with Part 4.1 directed to holding inmates for forensic processing. It refers in particular to offences which involve serious assaults, homicides or a suspected suicide of a cellmate.

140 Senior CO Osman Zerdo was the Night Senior or Officer in Charge in the early hours of 14 September 2020, when ZA died. He has provided a statement that because he did not suspect that Mr JH may have been involved in a crime, and

because he prioritised responding to the medical emergency presented by ZA condition, the procedures in section 4.1 were not carried out. He explained that because ZA required urgent medical assistance, he directed that Mr JH be removed from cell 233 in accordance with COPP 13.8, part 2.2 and took steps to secure cell 233 and restrict access to emergency medical personnel and responding officers.

141 Part 2.2 of COPP 13.8, which Senior CO Zerdo refers to, provides for securing perimeters and restricting access where an officer reasonably suspects that a serious incident has occurred, and the site must be treated as a crime scene.

Evidence on use of body scanning

142 Mr Williams gave evidence that body scanning is less intrusive form of searching, and has now been introduced into Shortland; every new inmate is scanned on arrival, although an inmate can still be strip searched.

143 Upon arrival the inmate will be put through the body scanner and if something is detected then they may be strip searched. Before the introduction of the body scanner, the procedure was that everyone was strip searched.

144 Mr Williams gave evidence to the inquest that a person trained in use of X-ray body scanners can see an anomaly, as opposed to a body part, on the image from the scanner. Anomalies detected should include inserted contraband which is not detectable on a strip search. Where a body scanner detects an anomaly, this can lead to further action, which can include a strip search or a referral to Justice Health for further examination, or placement in a dry cell.

145 Mr Williams stated that the X-ray body scanner can detect an anomaly that cannot be detected on the invasive style of strip search. However there is still an issue, as there can be some variances in the observations made by the trained personnel in how they detect and see the anomalies presented by the scan process. Mr Williams noted that contraband comes into correctional facilities by many methods. He was of the view that a low dose body scanner is more effective than a strip search in locating or revealing items secreted in

body cavities. The X-ray body scanners are being rolled out in maximum security facilities. There are resource and funding requirements that play a role in allocation of the X-ray scanning machines. As maximum-security facilities present significant risks, the scanning machines are being introduced there as a priority.

146 He told the inquest that X-ray scanners have been in use at Shortland since November 2020, however he is not aware if other centres had them prior, nor aware if the scanners were introduced specifically in response to ZA's death.

Formal findings pursuant to s81 of the Act

Identity and date and place of death

147 The evidence establishes that ZA died on 14 September 2020 at Shortland Correctional Centre. His identity was established on the evidence, and I note also that his partner provided an identification statement which is contained in the brief.

Cause of death

148 The cause of death is set out in the autopsy report of the forensic pathologist, Dr Clifton, as detailed above. Detailed examinations were undertaken, including toxicological examination. Post-mortem CT scans were also undertaken and showed no evidence of injury, and no suspicious injuries were detected. Post-mortem toxicological testing detected the presence of fentanyl at a level considered potentially lethal, especially in the context of ZA not being known to be prescribed this medication or to use it regularly. The pathologist explained in her report that Fentanyl is extremely potent (50 – 100 times the potency of morphine) with a rapid onset and short duration of action. It is known to cause respiratory centre depression, coma and seizures in high doses.

149 I am satisfied that fentanyl toxicity is responsible for ZA's death. There was no other significant natural disease to explain the death. There were no injuries to the body to suggest a third party was involved in the death. Post-mortem examination identified the presence of evolving aspiration pneumonia in the

lungs, which the pathologist found was likely representative of a prolonged period of unconsciousness (due to drug intoxication) in the period leading up to the death, which would have further compromised respiratory function and may have further hastened death.

150 The pathologist found the direct cause of death was fentanyl toxicity with a significant condition contributing to the death, but not relating to the disease or condition causing it, being aspiration pneumonia. I am satisfied on all the evidence that this was the cause of death and note the findings of the pathologist are consistent with other evidence at the inquest as to the circumstances of ZA's death.

Manner or circumstances of death

151 Mr JH's evidence makes clear that the circumstances of the death included that Mr JH supplied fentanyl to ZA, when Mr JH shared his fentanyl with ZA in the cell. Both Mr JH and ZA then fell asleep. Mr JH awoke to the sound of laboured breathing, rattling breath, and heard gurgling. When he turned ZA over liquid was discharged from ZA's mouth. The pathologist's findings that the evolving aspiration pneumonia in the lungs was likely representative of a prolonged period of unconsciousness, further compromising respiratory function, may explain why the efforts of both Mr JH and the significant efforts with CPR by correctional officers, including use of defibrillator, did not revive ZA - it is highly possible on the pathologist's findings that ZA had been unconscious for a period before the sound of his breathing, or laboured breathing, woke Mr JH.

152 Whilst it is clear that the ambulance took some 20 minutes to arrive, it is also clear that corrections officers undertook CPR and dedicated attempts to revive ZA and save his life. The family are concerned that there was no Narcan available given this can be successfully administered, in some cases of opiate overdose, to revive a person and save a person's life. It cannot be known whether ZA would have been revived if administered Narcan, however the concern to have that treatment option available for overdoses in gaol, is

reasonable, and is subject to further consideration below in these reasons for decision.

153 The evidence supports the finding that ZA self ingested the fentanyl. I accept that, on the evidence, this was out of character for ZA, he was not a regular opiate user. I note Mr JH's evidence at the inquest that gaol is a strange environment, it is not normal, and things that are not normal happen. It does not arise on the evidence that Mr JH would have given ZA the fentanyl without ZA wishing to share the substance – Mr JH had no motive to share the substance with ZA other than because his cellmate asked to share the substance. The evidence supports the finding that the fentanyl was self-administered.

154 There is no evidence on which to conclude that the fentanyl was ingested by ZA to end his own life, to the contrary all the evidence is against this conclusion. I therefore find that the overdose was accidental and the manner of death is misadventure.

Findings on issues

155 Prior to the inquest hearing a list of issues were circulated to parties. Findings on each of these issues are set out below.

The parties' submissions

156 All parties made oral submissions at the close of the hearing which addressed the findings that should be made on the evidence, and also proposed recommendations. In relation to the proposed recommendations, Counsel for the Commissioner for Corrective Services sought time to obtain instructions and respond. A timetable for limited further submissions on the appropriateness of proposed recommendations was set and the matter adjourned for findings.

157 Counsel Assisting made detailed submissions with which the other parties substantially agreed but with additional comments.

158 In relation to the emergency response provided by correctional officers at the time of ZA's death, all parties, including the family of ZA, agreed that the correctional officers who attended ZA's cell undertook their best efforts to try to save ZA's life and to provide life support to him.

159 The family made detailed submissions that recommendations should be made particularly in relation to provision of X-ray scanners at correctional facilities, and training to correctional officers in relation to response to overdose situations, and ready availability of Narcan. Mr O'Brien referred to the findings in a number of prior coronial inquests. In particular he referred to prior coronial findings about the supply of Narcan to first responders and the community, to try to reduce or prevent opioid deaths (Inquest into the death of DB and others (2016/00139604 and others), findings dated 1 March 2018). I agree that the discussion of Deputy State Coroner Graeme in her findings at paragraphs 107 to 128 is a useful reference, as it details the evidence presented in that inquest as to the usefulness and effectiveness of Naloxone in treating opioid overdoses, and the availability of Naloxone to first responders and in the community generally.

ISSUE 1

The appropriateness and adequacy of the search procedures and policies which applied in September 2020 upon reception of inmates at Kariong Intake and Transit Centre and Shortland Correctional Centre.

160 The evidence highlighted the reality that illicit substances are introduced into correctional centres, in a multitude of ways, including within body cavities of inmates and visitors.

161 In oral submission as the close of the inquest hearing, Counsel for the Commissioner of Corrective Services NSW noted that inmates can evade detection, and contraband will enter custodial facilities, but the policies are appropriate in relation to search procedures, and those procedures were followed by correctional officers in this case.

162 Any consideration of policy, and search procedures, must acknowledge that regardless of the process used to detect contraband, people will find ways to subvert it. There also remains a requirement to respect the dignity and rights of the majority of inmates and visitors who do not introduce contraband into gaols.

163 The evidence at this inquest indicated that strip searches may detect some concealed illicit substances but cannot detect all. Illicit substances in body cavities are difficult to detect by a strip search, and even the more invasive strip search may not detect the item.

164 Without some method to identify substances in body cavities, officers conducting searches, including strip searches, may not detect and thereby prevent the introduction of illicit substances.

165 It did not follow on the evidence at this inquest, that COPP 17.1, the applicable policy on how and when to conduct a strip search, was inadequate. Clause 46(5) of the Crimes Administration of Sentences Regulation 2014 (CAS Regulation) provides that a strip search of a person may include an examination of their body but not of the person's body cavities. This is the prescribed limit to how far a strip search can go. Policies and procedures are not permitted to exceed that limit.

166 The evidence of Correctional Officers Vidler and Jeffrey, detailed how, based on their experience, they determine when to conduct a more invasive strip search which involves requiring an inmate to squat or bend over or part their buttocks. COPP 17.1 limits the circumstances in which that kind of search can be conducted – the officer must have a reasonable suspicion that the person has something secreted. This in turn recognises the requirement of cl 46(3) CAS Regulation that searching must be conducted with due regard to dignity and self-respect.

ISSUE 2

The availability and efficacy of a low-dose X-ray body scanner as an alternative to being strip-searched upon reception of inmates at Kariong Intake and Transit Centre and/or Shortland Correctional Centre.

167 Evidence about the availability of low-dose X-ray body scanner at Kariong and Shortland was provided by Mr Williams. There are now three scanners at Shortland, they are available and in use. They were not in use in September 2020.

168 Mr JH had secreted the substance in his rectum when he was admitted to Shortland. We cannot know if the substance would have been detected by an X-ray scanner if such was in use at that time, however the possibility is that the secreted substance may have been detected.

169 I note the evidence that while individuals are trained in the use of the X-ray scanners, the interpretation involves human analysis; and it must be accepted that some degree of variance in interpretation, and error, can and will occur.

170 The evidence of Mr Williams indicates that the scanners are effective in reducing introduction of contraband, which must be considered a positive improvement in achieving the safety of inmates and security of correctional centres.

171 Mr Williams' evidence was that the scanners have been or will be implemented in other maximum security centres. Given Kariong is a transit centre, and Shortland is a maximum security centre, then it is understandable that scanners were first introduced at Shortland. The evidence in Mr William's written statement is to the effect that there is active consideration and proposals to introduce the scanners at Kariong. Whether Kariong is the appropriate next location for scanners is a matter for those who must balance resourcing and priorities, a complex exercise which would need to take into account many factors, consideration of which are outside the scope of this inquest. However, the evidence supports the introduction of scanners in correctional facilities, not

only in the interests of the management of custodial centres, but also in the interests of the safety of individual inmates.

ISSUE 3

The response by Corrective Services NSW officers to Mr JH's call at 3.31am on 14 September 2020, including in relation to management and monitoring of Mr JH until police arrived.

172 The response by Corrective Services officers to Mr JH's call was timely and appropriate. The evidence supports a finding that those officers did what they could. Officers gave evidence of the rarity of an event of this level of seriousness – the more senior officers, Zerdo and Panicker, had not had to deal with an overdose incident previously.

173 Faced with a medical emergency, the evidence indicates that every officer present at Shortland who could attend did attend. Every officer who attended was engaged in the effort to save ZA. Officer Panicker said the effort was exhausting. The scene was confronting and traumatic.

174 The evidence shows that Officer Zerdo was an effective and sound Officer-in-Charge that night. He was unquestionably right to concentrate the resources on trying to save ZA. He and his officers persisted until the paramedics arrived. The paramedics very quickly pronounced ZA as deceased.

175 The correctional officers were trained in first aid. All of the officers gave clear evidence about this. This first aid training was the training they most needed to provide an effective and life saving response, including in the retrieval and use of the defibrillator. Their evidence varied in their familiarity with the COPPs but it was ultimately Officer Zerdo who needed to ensure that they were complied with, and broadly speaking the policies were complied with. This is because all three applicable COPPs make clear, that in the case of a medical emergency, responding to that emergency must prevail over other considerations. Calling the ambulance on 000 was the first step under COPP 13.2, Medical Emergencies, part 1.1, and that is what happened. First aid must be provided under part 1.2, which occurred, including the sustained CPR efforts at, it should

be acknowledged, a time when NSW was truly in the grip of the COVID pandemic.

176 The officers complied with COPP 13.3 in that a death in custody must be initially responded to as a medical emergency. COPP 13.3 is important, because it touches upon the intersection of a medical emergency with a crime scene. It states that crime scene preservation procedures must be initiated but safety and emergency medical assistance take precedence.

177 The evidence indicates that cell 233 was disturbed as necessary for the resuscitation attempts, but preserving the scene was also a focus.

ISSUE 4

The appropriateness and adequacy of, and compliance with, applicable policies in relation to management and monitoring of cellmates during and after an incident involving potential drug overdose.

178 Considering issue 4 means returning to COPP 13.3, part 2.4, which provides that cellmates must be separated and secured for forensic processing by police, and refers to COPP 13.8 for crime scene preservation procedures.

179 After officers arrived at cell 233, Mr JH was placed immediately in cell 234 and that cell was locked. All the officers then attended to assisting ZA.

180 It is clear that if Mr JH had had contraband on his person when he was placed in cell 234 he could have disposed of it down the sink or toilet in cell 234. This did not involve any non- compliance with policy. Nor are the policies materially deficient. The conflation of a medical emergency with a potential crime scene gives rise to difficult and possibly competing priorities and actions. Consideration of what occurred has an inevitable hindsight advantage and, even in hindsight, the priority had to be and always was, trying to assist ZA.

181 In that context, it is to be remembered that although Mr JH reported an overdose in the knock up call, in responding to the crisis the focus would have been on

ZA's wellbeing and not on forensically analysing the situation to see if it was possible that Mr JH might be implicated.

182 It would have been contrary to policy for the officers, at the expense of the clear and appropriate directive that medical assistance takes priority, to prioritise holding inmates for forensic processing.

183 There is no evidence in this inquest to find that Part 4.1 of COPP 13.8, as far as it goes, is not appropriate. It provides a procedure designed to protect forensic evidence on the person of an inmate from damage, destruction or disposal.

184 Mr JH had opportunity to dispose of the substance on his person while he was waiting in cell 234. His evidence that he did not do so, and that he remains of the belief that he passed it into the bucket in the dry cell, may be accepted, but that does not resolve this issue.

185 Evidence was heard from Officers Panicker and Zerdo that switching water off in a cell can be done easily and quickly.

Recommendations proposed by Counsel Assisting – proposed recommendation 1

186 Counsel Assisting proposed that the evidence provides a basis for a recommendation in the terms of s 82 of the Coroners Act, that Corrective Services reviews COPPS 13.2, 13.3 and 13.8 for the purpose of identifying whether all or one of them should be amended. It was submitted that possible approaches may include:

- COPPS 13.2 could be amended to cross-refer to the situation where a medical emergency is also potentially a crime scene. Presently this is contemplated by COPPS 13.3, which is about deaths in custody, but not by COPPS 13.2, which is about medical emergencies.

- Examples of the kind of amendment that might be made, if appropriate, is to include wording to the effect of what is in COPP 13.3 in paragraph 2.4.

- COPS 13.3 could be amended in paragraph 2.4 to state to the effect that cellmates or suspected assailants must be separated and secured for forensic processing, which may include placing in a dry cell, and retaining the present cross-reference to COPP 13.8, crime scene preservation.

- It should be the case that any amendment to policy would flow through in appropriate training.

187 Counsel Assisting submitted that such changes in the policies might make it more recognisable by Correctional Officers that:

(a) a single situation can invoke more than one response while still retaining the message that medical assistance where needed is paramount; and

(b) the notion of "securing" a cellmate for forensic processing in an appropriate case may mean a dry cell (be that, by turning the water off in a cell, or in a specially allocated cell, or otherwise).

188 Counsel Assisting submitted that she would not advocate for rigid or inflexible policy because of the practical reality that no policy can meet the exigencies of all possible crisis situations, and officers need to be able to exercise a degree of discretion in responding each time.

Submission in response from Corrective Services

189 Corrective Services responded to Counsel Assisting's proposed recommendation as follows:

> Counsel Assisting suggested that the Coroner might consider recommending that Corrective Services NSW ("CSNSW") review Custodial Operations Policy and Procedures ("COPP") sections 13.2, 13.3 and 13.8 for the purpose of identifying whether all or one of them should be amended.
>
> The Commissioner accepts Counsel Assisting's suggested recommendation. A review will be undertaken by CSNSW and the various approaches to amendment outlined by Counsel Assisting in her submissions will be considered.

Finding on recommendation 1

190 Noting the recommendation is a suitable recommendation on the evidence in this inquest, and is accepted by Corrective Services, then I make the following recommendation.

Recommendation 1

That Corrective Services NSW ("CSNSW") review Custodial Operations Policy and Procedures ("COPP") sections 13.2, 13.3 and 13.8 for the purpose of identifying whether all or one of them should be amended.

Recommendations proposed by family of ZA

191 The family of ZA proposed recommendations which they envisaged might reduce the risk of future deaths due to overdose on illicit drugs in gaols. The legal representative of the family, Mr O'Brien, also referred to a number of prior coronial findings. As noted above the findings of Deputy State Coroner Graeme in the Inquest into the death of DB and others (2016/00139604 and others), findings dated 1 March 2018, were particularly relevant in relation to use of naloxone in opioid overdoses and availability in community and to first responders. The recommendations proposed by family were as follows.

X-ray scanners

192 That NSW Corrective Services consider the widespread introduction of low dose X-ray body scanners across all NSW correctional centres as a tool for

contraband interception in lieu of routine strip searches for prisoners who arrive freshly into correctional centres.

Naloxone (Narcan)

193 That NSW Corrective Services investigate the provision of Naloxone to corrective services officers as medication to assist in cases of opioid overdose, especially and urgently in correctional centres where Justice Health medical practitioners are not present at all times of the day and night.

Training

194 That NSW Corrective Services provide training to all NSW correctional service officers particular to dealing with a medical emergency where an inmate has overdosed, and further that procedures for dealing with that type of medical emergency be incorporated into COPP 13.2 – Medical Emergencies.

Medical officers

195 That Justice Health & Forensic Mental Health Network urgently implement a 24-hour roster for medical staff at Shortland Correctional Centre and give consideration to implementing the same in other correctional centres where JH medical staff are not available 24 hours 7 days per week.

Provision of information from this inquest to Justice Health

196 That Justice Health & Forensic Mental Health Network be provided with a transcript of the evidence of Senior Corrective Officer Osman Zerdo, and the findings of this Inquest.

An Observation - Justice Health not a party to this inquest

197 It was noted during the submission of parties as to the making of the recommendations, that Justice Health was not a party to the inquest, not having been earlier identified as having a sufficient interest. Further the issues for

examination at the inquest did not involve Justice Health. It was resolved that the solicitors assisting the Coroner would write to Justice Health to see if they wished to make any comment, but noting that they were not obliged to, given they were not a party. However it was noted that it would not be inappropriate to send a transcript of Senior CO Zerdo's evidence which was eloquent in his wish for medical backup, to Justice Health, in addition to these Reasons for Decision.

Response by Commissioner for Corrective Services to proposed recommendation for X-ray scanners made by the family

198 In submissions provided by the Commissioner for Corrective Services in response to the recommendation proposed by the family, in relation to X-ray scanners, it is stated as follows:

> The Family proposed a recommendation that CSNSW consider the widespread introduction of low dose X-ray body scanners across all NSW correctional centres as a tool for contraband interception, in lieu of routine strip searches for prisoners who arrived freshly into correctional centres.
>
> In principle, the Commissioner supports the introduction of low dose X-ray body scanners ("body scanners") into correctional centres. However, there is a cost involved in that process. CSNSW has to prioritise the introduction of body scanners based on risk assessment. There are currently 65 body scanners in 24 locations across the State, which includes maximum security facilities (such as Shortland Correctional Centre) and those that hold female inmates.
>
> The Commissioner accepts the submission by Counsel Assisting that the best location for body scanners *"is appropriately a matter for those who must balance resourcing and priorities, no doubt a complex exercise which would need to take into account many factors, consideration of which are outside the scope of [the Coroner's] functions in this inquest"*
>
> The Commissioner respectfully submits that a recommendation concerning the introduction of body scanners across all NSW correctional centres is not necessary or appropriate in the circumstances.

Finding on proposed recommendation for X-ray scanners

199 I note that Corrective Services already have a process of installation of X-ray scanners, scanners are installed in Shortland and it is proposed that scanners

be installed in Kariong. I am of the view, given these changes, that a formal recommendation is not required.

Commissioner's response to proposed recommendation for provision of Naloxone (Narcan)

200 In response to the family's proposed recommendation for provision of Naloxone the Commissioner of Corrective Services submits:

> The Family proposed a recommendation that CSNSW investigate the provision of Naloxone (aka Narcan) to correctional officers as medication to assist in cases of opioid overdose, especially and urgently in correctional centres where Justice Health medical practitioners are not present at all times of the day and night.
>
> The Commissioner acknowledges that Naloxone is a lifesaving medicine that reverses the effects of opioid overdose and that illegal opioids can enter correctional centres undetected. The Commissioner agrees there are benefits to exploring the concept of making Naloxone available to correctional officers.
>
> CSNSW intends to propose the formation of a working party with the Justice Health and Forensic Mental Health Network to investigate how this may be achieved in practice.

201 Noting the support of the Commissioner of Corrective Services for provision of Naloxone/Narcan, and given I am satisfied of the potential benefit of such provision in preventing future deaths, then I make the following recommendation:

Recommendation 2

That CSNSW investigate the provision of Naloxone (aka Narcan) to correctional officers as medication to assist in cases of opioid overdose, especially and urgently in correctional centres where Justice Health medical practitioners are not present at all times of the day and night.

202 It is noted the Corrective Services propose to form a working party with the Justice Health and Forensic Mental Health Network to investigate how this may be achieved in practice.

Commissioner's response to proposed recommendation for training for correctional officers in responding to overdoses

203 The Commissioner for Corrective Service submits, in relation to the family's proposed recommendation - that CSNSW provide training to all correctional officers particular to dealing with a medical emergency where an inmate has overdosed, and further that procedures for dealing with that type of medical emergency be incorporated into COPP 13.2 Medical emergencies – as follows:

> Upon commencement of employment with CSNSW, trainee correctional officers must successfully complete training and assessment against the Provide First Aid unit of competency as part of the initial 10-week face to face program delivered by the Brush Farm Corrective Services Academy ("BFCSA"). Within this program, the signs/symptoms of an alcohol/drug overdose and associated management strategies are identified. Correctional officers also participate in scenarios involving unconscious and non-breathing casualties wherein they must meet required industry/assessment benchmarks.
>
> It is mandatory that correctional officers maintain their currency in First Aid by completing training and assessment for the associated unit of competency every three years. This training and assessment is provided both at BFCSA and on-site at regional locations.
>
> As correctional officers are not medically trained and are not recognised as health practitioners, COPP 13.2 requires officers to call NSW Ambulance (and then Justice Health, if available) as the first step in a medical emergency. The second step is to provide First Aid while awaiting medical assistance (Tab 63, Vol. 2 – COPP 13.2 Medical Emergencies, parts 1.1 and 1.2 (pg 4). The Commissioner notes, and supports, Counsel Assisting's submission that "[First Aid training] was the training [correctional officers] most needed in the response, including in the retrieval and use of the defibrillator."
>
> In the above circumstances, the Commissioner respectfully submits that a recommendation with respect to additional training and procedures on dealing with medical emergencies involving overdoses are not necessary.

Finding on proposed recommendation for training for correctional officers in responding to overdoses

204 Taking into account the evidence of the response provided by the correctional officers in this matter, in providing first aid to ZA, and noting the support for a further first aid measure in relation to provision of naloxone, then I am of the

view that a formal recommendation in relation to additional first aid training is not required at this time.

Formal findings under s 81

The identity of the deceased is ZA.

The date of death was 14 September 2020.

The place of death was Shortland Correctional Centre, Lindsay Street, Cessnock, NSW, 2325.

The cause of death was Fentanyl toxicity, with a significant condition contributing to the death but not relating to the condition causing it being aspiration pneumonia.

The manner of death was misadventure.

Closing

205 I acknowledge and express my gratitude to the Counsel Assisting the Coroner, Ms Anne Bonnor, and her instructing solicitor from the Crown Solicitors Office, Ms Sarah Crellin, for their assistance both before and during the inquest. I also thank the investigating Police Officers, and in particular the Officer in Charge, Sergeant Ayscough, for his work in the Police investigation and compiling the evidence for the inquest.

206 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences to the family of Mr ZA.

207 I close this inquest.

Magistrate Carolyn Huntsman

Deputy State Coroner

Coroners Court of New South Wales

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Annexure NPO

Non Publication Order

1. That the following information or documents, contained in the brief of evidence tendered in the proceedings, not be published under section 74(1)(b) of the *Coroners Act 2009* (NSW) ("**the Act**"):

    a. The names, Master Index Numbers (MINs) and any other personal information of people in the custody of Corrective Services NSW ("**CSNSW**") excluding Mr JH and Andrew Boers.

    b. The names, Visitor Index Numbers (VINs), telephone numbers, residential addresses, and any other personal information of any member of ZA's and Mr JH's family, friends and/or visitors, other than legal or professional visitors.

    c. The direct contact details of CSNSW staff members and staff members of external service providers that are not publicly available.

    d. Still photographs contained in the CSNSW Serious Incident Report at tab 6A of the brief of evidence.

    e. The 'N Watch OIC's Journal' dated 14 September 2020 at tab 56 of the brief of evidence.

    f. Information contained in the following sections of the CSNSW Custodial Operations Policy and Procedures ("**COPP**"), as set out in the schedule annexed and marked "A" ("**Schedule A**"):

        i. Section 13.3 *Death in custody* (version 1.0) at tab 64 of the brief of evidence;

        ii. Section 13.1 *Serious Incident Reporting* (version 1.2) at tab 64A of the brief of evidence;

        iii. Section 13.8 *Crime scene preservation* (version 1.0) at tab 64B of the brief of evidence.

        iv. Section 17.5 *Body scanning* (version 1.1), annexed to the statement of Michael Williams at tab 25A of the brief of evidence.

    g. The Police Service Intelligence Information System, information report summary contained at Tab 40B.

    h. Any footage of F Block of Shortland Correctional Centre.

2. Insofar as an order made under paragraph 1 above concerns any matter that identifies ZA and/or a relative of ZA, the order is also made pursuant to s 75(1) of the *Coroners Act 2009*.

3. Pursuant to section 65(4) of the Act, a notation be placed on the Court file that if an application is made under section 65(2) of the Act for access to any CSNSW documents on the Court file, that material shall not be provided until CSNSW has had an opportunity to make submissions in respect of that application.

ANNEXURE A
(Refer next page)

ANNEXURE A

Schedule to Short Minutes of Order

Order number	Portion of document over which an order pursuant to s 74(1)(b) of the Coroners Act 2009 (NSW) is made (with reference to the tabs and page numbers in the coronial brief of evidence tendered in the inquest on 22 August 2022)
1.f.i.	<u>Tab 64</u> • The sentence starting with *"Cellmates or suspected assailants…"* in part 2.4 'Crime scene preservation' on page 6. • The telephone number in part 6.1 'Aboriginal Strategy and Policy Unit' on page 12.
1.f.ii	<u>Tab 64A</u> • Telephone numbers in part 2.5 'Telephoning the duty officer' on page 5, and in part 3.1 'Timeframes for IRM reporting' on page 7. • Email addresses in part 2.6 'Briefing Note' on page 6 and in part 4.1 'Incident and witness reports' on page 9.
1.f.iii	<u>Tab 64B</u> • The entire contents <u>excluding</u> the third and fifth paragraphs starting with *"For forensic evidence on victims…"* and *"Any forensic evidence must be protected…",* respectively, of part 4.1 'Holding inmates for forensic processing' on page 11.
6	<u>Tab 25A – Annexure to Micheal Williams' statement</u> • The words within the brackets in the third paragraph starting with *"(e.g. where a person…"* in part 1.1 'Policy' on page 5. • The words within the brackets in the second paragraph starting with *"(i.e. where they…"* in part 3.2 'Additional policy for body scanning female inmates' on page 10. • The entire last paragraph in row 5 of the table in part 3.3 'Conducting a body scan on inmates', starting with *"Note: Where an inmate…"* on page 12. • In the same table referred to above, the second and third sentences in row 8, point c), starting from *"Do not…"* on page 12. • The words within the brackets in the second paragraph starting with *"(i.e. where…"* in part 4.1 'Policy' on page 14.